CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

Patient's Name **Date of Birth** **HR#:**

Dear Patient:
This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened:_____

_____

_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

_____

_____

Did you require post-accident hospitalization? ☐Yes☐No

Check symptoms you have noticed since the accident:

___ Headache	___ Dizziness	___ Depression	___ Fatigue
___ Light Bothers Eyes	___ Buzzing in Ears	___ Diarrhea	___ Neck Pain
___ Head Seems to Heavy	___ Memory Loss	___Feet Cold	___ Neck Stiff
___ Pins and Needles in Arms	___ Ears Ring	___ Hands Cold	___ Fainting
___ Sleeping Problems	___ Back Pain	___ Face Flushed	___ Loss of Balance
___ Pins and Needles in Legs	___ Constipation	___ Tension	___ Nervousness
___ Numbness in Fingers	___ Loss of Smell	___ Fever	___ Irritability
___ Numbness in Toes	___ Loss of Taste	___ Chest Pain	___ Cold Sweats
___Shortness of Breath	___Stomach Upset		

Symptoms other than above: _____

_____

Where were you taken after the accident? _____

Hospitalized? ☐Yes☐NoIf yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctor(s): _____

What treatment was given? _____

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Was any other doctor consulted after your accident? ☐Yes☐No

If so, what was the doctor's name? _____D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given?_____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐Yes☐No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐Yes☐No

Are your work activities restricted as a result of this accident? ☐Yes☐No

Since this injury are your symptoms …☐Improving? ☐ Getting worse? ☐Same?

Driver of other vehicle (if any):

Name_____ Insurance Company_____ Policy No. _____

Driver of vehicle in which you were injured (if applicable):

Name _____Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? ☐Yes☐No

If so, his/her name and address_____

You were heading North/ East/ South/ West on _____(street or highway)

Other vehicle was heading North/ East/ South/ West on _____(street or highway)

Were police notified? ☐Yes☐No

Were you knocked unconscious? ☐Yes☐No If yes, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side_____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts_____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____